Interagency Pharmaceuticals Purchasing Study Group
Meeting Minutes | September 20, 2019
House Hearing Room, 2nd Floor of Legislative Hall (411 Legislative Avenue, Dover, DE 19901)

Co-chair Representative Raymond Seigfried called the meeting to order at 1:32 pm.

Members present include Co-Chair Seigfried, Tony Ward, Trinidad Navarro, Faith Rentz, Stephen Groff, Richard Margolis, Marc Richman, Secretary Kara Odom Walker, and Victoria Brennan. Also present were Christina Bryan, Lizzie Lewis, Deanna Killen (on behalf of Senator Pettyjohn), Hooshang Shanehsaz, Fred Gibison, Joana Nassa, and Abigail Stoddard.

Co-Chair Seigfried asked committee members to review the meeting minutes from the July 19th meeting.

Mr. Groff made a motion to approve the minutes. Secretary Walker seconded the motion, and the meeting minutes from July 19, 2019 were approved.

Ms. Rentz of the Department of Human Resources provided a presentation on State Group Health Program PBM contracting. Please refer to Appendix 1 at the end of these minutes. The presentation covered prescription coverage for state employees and retirees; PBM services contracting and procurement; pharmacy benefit management services; state group health program trends; trends in indications and specialty drugs; healthcare spending trends; and limitations and areas of concerns.

Co-Chair Seigfried asked if pharmacy benefit manager (PBM) or the statewide benefits office determines the drug utilization review for the state plans.

Ms. Rentz replied that the PBM will approach the benefits office with different plan options, and the office will choose. She added that PBMs are providing more value-based plans.

Co-Chair Seigfried remarked that Louisiana has implemented a Netflix-style subscription model.

Dr. Walker remarked that Louisiana's problem was a lack of covered drugs, so they sought to negotiate directly with insurers. She said it was not clear that Delaware would benefit from engaging in that type of direct negotiation.

Ms. Rentz commented that the state is doing well with generic drug utilization compared to peer states.

Co-Chair Seigfried asked for trends in generic drug utilization.

Ms. Rentz replied that the state has very deep discounts for generic drugs, so that is an area where their spending is relatively controlled.

Co-Chair Seigfried asked if the state group health historical pharmacy spending data includes rebates.

Ms. Rentz replied that the data does include rebates, which decreases the cost by millions of dollars for both commercial and EGWP plans.

Stephen Groff, Division of Medicaid and Medical Assistance, Delaware Department of Health and Social Services, provided a presentation on Medicaid as it relates to pharmaceutical purchasing. Please refer to Appendix 2. He covered the processes through which Medicaid pays pharmacies for the cost of drugs dispensed to Medicaid. His presentation explained the three factors that contribute to Medicaid drug costs: ingredient costs, dispensing fees, and drug rebates. Finally, Stephen provided an overview of Medicaid pharmacy expenditures and cost drivers by therapeutic class and drug name.

Co-Chair Seigfried asked if rebate programs vary from state to state.

Mr. Groff replied that all states participate in the federal drug rebate program.

Mr. Groff noted that in some cases, brand drugs can be less expensive than the generics due to drug rebates.

Co-Chair Seigfried asked if this occurs often.

Ms. Rentz replied that typically there are eight to ten brand drugs that are charged at the generic level at any given time.

Mr. Groff added that this concept can cause confusion when looking at Medicaid cost data.

Mr. Richman asked if the drug rebate program comes back to DHSS or to the General Fund.

Mr. Groff replied that the Division retains the state portion of the rebate, but the annual budget accounts for those funds.

Mr. Richman presented on the Department of Corrections pharmacy spending. Please refer to Appendix 3 at the end of these minutes. He provided key data points relevant to the Department including spending trends, major cost drivers, and essential components of the Department's pharmacy contract. He highlighted the Department has full time pharmacists on site on the state's level 5 prisons. Mr. Richman emphasized the positive impact that these pharmacists have on health outcomes and cost control.

Ms. Rentz expressed her appreciation for Mr. Richman and Mr. Groff's work. She commented that both groups essentially do the work of a pharmacy benefit manager.
Dr. Walker provided comments on the Delaware Psychiatric Center and the Delaware Hospital for the Chronically Ill and emphasized that any policy solution should take those facilities into consideration. She offered to have her Department's team provide data on those facilities.

Co-Chair Seigfried provided information on non-task force members who had been invited to contribute to the work of the group. He invited Hooshang Shanehsaz to introduce himself and his work as a pharmacist.

Mr. Shanehsaz introduced himself and his work as a contractor for the Department of Health and Social Services.

Co-Chair Seigfried distributed information on potential conflicts of interests that may arise from inviting outside participants to provide expertise to the committee. Please refer to Appendix 4. He mentioned that he asked an attorney to research this information so that the committee could take an extra precaution in bringing in outside input. He also introduced a potential consultant.

Fred Gibison from Mercer Health and Benefits introduced himself and commented on his work with DMMA and other states in Mercer's government healthcare practice. He stressed that Mercer is a consulting firm not a PBM, which mitigates potential conflicts of interests.

Abigail Stoddard of Mercer Health and Benefits introduced herself and provided context on her work as a pharmacist.

Joanna Nassa of Mercer Health and Benefits introduced herself and commented on her expertise in collective purchasing and negotiating contracts.

Mr. Groff commented that the work of the committee aligns with the current scope of work outlined in DMMA's contract with Mercer Health and Benefits.

Co-Chair Seigfried stated that another opportunity might be to engage the DHIN.

Co-Chair Seigfried presented committee members with a memorandum of best practices from the National Conference of State Legislatures (see Appendix 5). He then provided the date for the next meeting and adjourned the meeting at 2:25 pm.

These minutes were respectfully submitted by:

Taylor Hawk
Executive Assistant to Senator Nicole Poore.

Appendix 1

Statewide Benefits Office

SBO

Benefits Made Easy

State Group Health Program PBM Contracting

Interagency Pharmaceuticals Purchasing Study Group

September 20, 2019

Prescription Coverage for State Employee and Retirees

- State Employee Benefits Committee (SEBC) has statutory authority over plan design/cost sharing for prescription benefits

- Administered by a Prescription Benefit Manager (PBM)
  - Commercial Plan for employees/non-Medicare retirees
  - Employer Group Waiver/Medicare Part D (EGWP) plan with enhanced coverage for Medicare retirees

Timeline for Recontracting/Procurement of PBM Services

- Currently in year 4 of a 5 year contract with Express Scripts
  - Commercial plan end date – 6/30/21
  - EGWP/Part D plan end date – 12/31/21

- SEBC will renegotiate terms with ESI for year 5 by 3/31/20 for July 1, 2020 effective date

- SEBC will release a Request for Proposal for new contract effective July 1, 2021
  - Advertise August 2020
  - Contract Award December 2020

Pharmacy Benefit Management Services

Claims Processing

Price, Discount and Rebate Negotiations with Pharmaceutical Manufacturers and Drugstores

Formulary Management

Pharmacy Networks

Mail-service Pharmacy

Specialty Pharmacy

Drug Utilization Review

Disease Management and Adherence Initiatives

Member Copay Structure
Commercial and Medicare Part D

Prescription Drugs	In-Network	Retail & Mail-Order 90-day Supply	Out-of-Network
Tier One – Generic	$8 copay	$16 copay	Not Covered
Tier Two – Preferred	$28 copay	$56 copay	Not Covered
Tier Three – Non-Preferred	$50 copay	$100 copay	Not Covered
Preventive Drugs*	Certain prescription drugs classified as preventative under the Affordable Care Act are covered at 100% ($0 copay)		Not Covered

* Applies only to Commercial Coverage

EGWP/Part D Plan Design

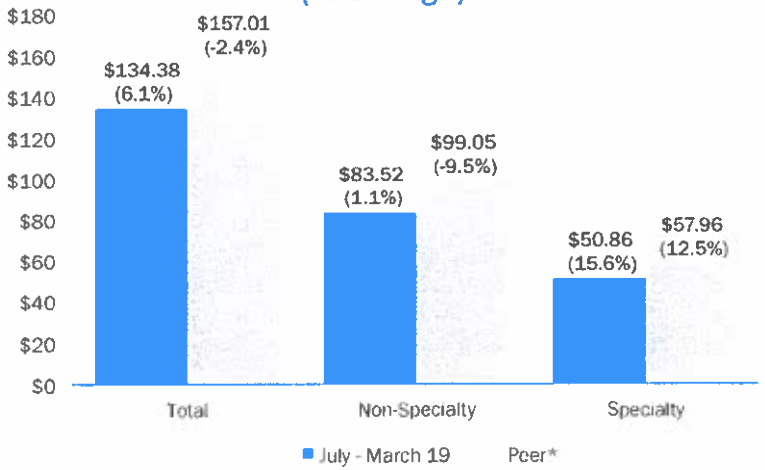
Enhanced Design Gives Medicare Retiree Same Coverage as Employee

Part D Benefit Stage	Rx Drug Costs*	Standard Part D Plan	State of Delaware EGWP Plan Design
1 Deductible	$0–$435	**Member pays 100% of the network discounted cost**	■ Coverage with applicable copay
2 Initial Coverage	$436–$4,020	**The member is considered "in-benefit" and pays the applicable co-payment/ co-insurance**	■ Coverage with applicable copay
3 Coverage Gap	$4,021–**$6,350 TrOOP**	**Coverage Gap Discount Program (70% discount on brands).** Donut hole filled in 2019 for brand drugs; donut hole filled for all drugs in 2020	■ Coverage with applicable copay
4 Catastrophic Coverage	**$6,350 + TrOOP**	**The member is back "in-benefit" and pays lower co-payment amounts defined by CMS**	■ Lessor of copay or CMS standard member cost share limit of approximately 5%. Plan pays 15%, federal reinsurance 80%

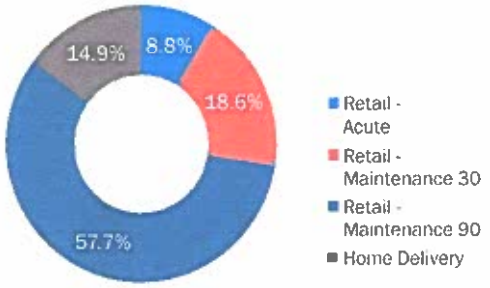
For EGWP, only two phases are required by CMS (Initial Coverage and Catastrophic Coverage)
* These figures are for CY2020, as released in the Call Letter dated 4/1/2019

State Group Health Program Trend Dashboard

Plan Cost Net PMPM (% Change)



Days Supply by Channel



State of Delware Commercial and EGWP				Peer*	
Description	July - March 19	July - March 18	Change	July - March 19	Change
Average Members per Month	125,824	124,059	1.4%		
Total Plan Cost Net	$152,174,239	$141,395,042	7.6%		
Average Member Age	43.2	43.1	0.2%	45.0	
Total Plan Cost Net PMPM	$134.38	$126.64	6.1%	$157.01	-2.4%
Non-Specialty Plan Cost Net PMPM	$83.52	$82.64	1.1%	$99.05	-9.5%
Specialty Plan Cost Net PMPM	$50.86	$44.00	15.6%	$57.96	12.5%
Generic Fill Rate	84.3%	84.0%	0.3	83.3%	0.5
90 Day Utilization	72.6%	73.0%	-0.4	46.0%	-0.5
Retail - Maintenance 90 Utilization	57.7%	58.6%	-1.0	6.5%	0.4
Home Delivery Utilization	14.9%	14.4%	0.6	39.5%	-0.9
Member Cost Net %	9.6%	10.0%	-0.3	7.0%	0.3
Specialty Percent of Plan Cost Net	37.8%	34.7%	3.1	36.9%	4.9

Peer = Government Northeast Region

Top 10 Indications

- The largest financially impactful change was in Cancer, driving $5.1M in increased net cost
- Cancer trend increased 29.2%, contributing an additional $4.26 to Net PMPM
- Generic Fill Rate (GFR) in Anticoagulant lags peers by 7.7 points

Represents
61.0%
Of Total
Plan Cost Net

Top Indications by Plan Cost Net

				July - March 19					July - March 18				% Change
AUM Strategy	Rank	Peer Rank	Indication	Rxs	Patients	Plan Cost Net	Generic Fill Rate	Peer Generic Fill Rate	Rank	Rxs	Patients	Generic Fill Rate	Plan Cost Net PMPM
ST/PA/DQM	1	1	CANCER	4,870	1,313	$21,322,460	70.8%	70.3%	3	4,233	1,225	70.5%	29.2%
ST/PA/DQM	2	2	INFLAMMATORY CONDITIONS	6,161	1,633	$19,280,219	52.2%	50.0%	1	5,923	1,549	52.9%	11.9%
ST/PA/DQM	3	3	DIABETES	79,307	11,825	$17,371,777	38.9%	39.1%	2	77,585	11,659	38.2%	2.9%
ST/PA/DQM	4	4	MULTIPLE SCLEROSIS	465	150	$6,700,318	20.4%	19.0%	4	514	157	8.9%	-4.6%
ST/PA/DQM	5	5	PAIN/INFLAMMATION	98,817	29,618	$5,845,722	93.5%	92.6%	5	102,244	30,348	93.2%	-6.9%
PA	6	7	ANTICOAGULANT	14,672	4,060	$5,675,079	25.7%	33.5%	7	13,209	3,805	33.2%	13.7%
ST/DQM	7	6	HIGH BLOOD PRESS/HEART DISEASE	198,516	37,485	$4,684,873	98.5%	97.6%	8	183,975	36,644	98.2%	3.4%
ST/PA	8	18	ATTENTION DISORDERS	31,199	5,183	$4,079,007	46.0%	51.9%	9	30,796	5,164	48.3%	-3.0%
ST/PA/DQM	9	10	HIGH BLOOD CHOLESTEROL	91,288	28,224	$3,920,646	96.8%	95.9%	6	84,912	27,657	96.7%	-23.4%
N/A	10	8	HIV	1,262	214	$3,893,967	9.7%	16.5%	11	1,179	187	7.5%	13.7%
			Total Top 10:	526,557		$92,774,067	82.1%			504,570		81.9%	7.6%
			Differences Between Periods:	21,987		$7,797,294	0.2%						

Peer = Express Scripts Peer 'Government - Northeast Region' market segment

Top 25 Drugs

- Represent 29.3% of total Plan Cost Net and comprise 10 indications
- 13 of top 25 are specialty drugs, making up 57.7% of Top 25 spend

Top Drugs by Plan Cost Net

					July - March 19			July - March 18			% Change
AUM Strategy	Rank	Peer Rank	Brand Name	Indication	Rxs	Pts.	Plan Cost Net	Rank	Rxs	Pts.	Plan Cost Net PMPM
ST/PA/DQM	1	1	HUMIRA PEN*	INFLAMMATORY CONDITIONS	642	198	$5,918,888	1	814	239	-8.1%
PA	2	2	REVLIMID*	CANCER	327	47	$4,905,706	2	280	43	34.0%
PA	3	3	ELIQUIS	ANTICOAGULANT	5,649	1,573	$2,740,626	4	4,039	1,215	32.2%
PA/DQM	4	6	TRULICITY	DIABETES	3,429	937	$2,660,039	3	2,753	764	20.8%
PA	5	9	XARELTO	ANTICOAGULANT	4,423	1,248	$2,166,319	5	3,695	1,151	7.6%
ST/PA	6	26	VYVANSE	ATTENTION DISORDERS	7,726	1,660	$1,902,732	10	7,364	1,652	7.9%
ST	7	22	GILENYA*	MULTIPLE SCLEROSIS	116	35	$1,861,208	6	120	39	-5.9%
ST/PA/DQM	8	5	ENBREL SURECLICK*	INFLAMMATORY CONDITIONS	241	74	$1,786,100	7	243	81	-3.4%
PA/DQM	9	14	IBRANCE*	CANCER	141	22	$1,648,483	9	160	27	-8.8%
ST/PA	10	4	STELARA*	INFLAMMATORY CONDITIONS	153	53	$1,570,386	12	136	47	11.8%
PA/DQM	11	7	IMBRUVICA*	CANCER	115	17	$1,563,225	19	84	13	61.5%
ST	12	13	LYRICA	PAIN/INFLAMMATION	2,593	756	$1,550,572	8	2,467	720	-14.4%
ST/DQM	13	8	JANUVIA	DIABETES	4,085	1,329	$1,524,872	11	3,819	1,308	-1.7%
ST	14	10	TECFIDERA*	MULTIPLE SCLEROSIS	70	27	$1,339,367	14	76	30	1.2%
PA/DQM	15	43	SPRYCEL*	CANCER	66	13	$1,278,535	16	51	13	22.3%
ST/PA/DQM	16	16	VICTOZA 3-PAK	DIABETES	952	322	$1,203,670	13	1,057	377	-12.2%
ST/DQM	17	20	JARDIANCE	DIABETES	2,052	724	$1,188,653	46	1,339	474	90.1%
ST	18	18	METFORMIN ER GASTRIC	DIABETES	176	69	$1,129,282	17	151	70	10.7%
ST/PA	19	19	OTEZLA*	INFLAMMATORY CONDITIONS	315	81	$1,083,497	26	245	76	30.4%
ST/PA/DQM	20	17	XTANDI*	CANCER	93	22	$1,073,293	21	86	17	17.7%
N/A	21	42	MYRBETRIQ	URINARY DISORDERS	2,369	821	$951,728	34	1,901	668	24.2%
DQM	22	46	LATUDA	MENTAL/NEURO DISORDERS	633	176	$939,573	37	569	161	26.6%
N/A	23	23	GENVOYA	HIV	227	42	$916,811	25	205	37	10.0%
PA/DQM	24	87	TASIGNA*	CANCER	42	10	$885,682	45	29	9	37.2%
ST/PA	25	27	COSENTYX PEN (2 PENS)*	INFLAMMATORY CONDITIONS	154	46	$832,378	55	88	26	56.5%
				Total Top 25:	36,789		$44,621,624		31,771		11.1%
				Differences Between Periods:	5,018		$5,016,949				

*Specialty Drugs

Peer = Express Scripts Peer 'Government - Northeast Region' market segment

Top 10 Specialty Indications

- The largest financially impactful change in Specialty was in Cancer, driving $4.8M in increased net cost from a 28.6% increase in Net PMPM
- Skin Conditions trend increased 218.6%, contributing an additional $0.45 to Specialty Cost Net PMPM
- Immune Deficiency has a larger impact on spend than it does on peers, ranked 21 vs 45

Top Specialty Indications by Plan Cost Net												
			July - March 19				July - March 18				% Change
AUM Strategy	Overall Rank	Overall Peer Rank	Indication	Rxs	Patients	Plan Cost Net	Overall Rank	Rxs	Patients	Plan Cost Net	Plan Cost Net PMPM
ST/PA/DQM	1	1	CANCER	1,668	318	$20,561,262	3	1,420	290	$15,770,227	28.6%
ST/PA/DQM	2	2	INFLAMMATORY CONDITIONS	2,320	670	$17,381,371	1	2,115	617	$15,054,435	13.8%
ST/PA/DQM	4	4	MULTIPLE SCLEROSIS	465	150	$6,700,318	4	514	157	$6,926,396	-4.6%
ST/PA/DQM	20	25	PULMONARY HYPERTENSION	309	41	$1,762,812	20	306	43	$1,627,838	6.8%
PA	21	45	IMMUNE DEFICIENCY	160	27	$1,543,957	36	114	18	$824,387	84.7%
PA/DQM	28	32	IDIOPATHIC PULMONARY FIBROSIS	125	22	$1,251,824	30	128	20	$1,152,193	7.1%
ST/PA/DQM	29	38	OSTEOPOROSIS	306	117	$1,022,389	26	331	122	$1,084,187	-7.0%
ST/PA/DQM	34	35	BLOOD CELL DEFICIENCY	130	41	$919,754	24	138	47	$1,363,730	-33.5%
PA/DQM	40	39	CYSTIC FIBROSIS	95	14	$772,999	42	79	15	$615,862	23.8%
ST/PA/DQM	12	11	SKIN CONDITIONS	229	54	$747,584	16	68	16	$231,357	218.6%
			Total Top 10:	5,807		$52,664,271		5,213		$44,650,613	16.3%
			Differences Between Periods:	594		$8,013,658					

Peer = Express Scripts Peer 'Government - Northeast Region' market segment

Top 25 Specialty Drugs

- Represent 22.4% of total Plan Cost Net and comprise 7 indications

Top Specialty Drugs by Plan Cost Net

									July - March 19				July - March 18				% Change
AUM Strategy	Overall Rank	Overall Peer Rank	Brand Name	Indication	Rxs	Pts.	Plan Cost Net	Plan Cost Net / Rx	Overall Rank	Rxs	Pts.	Plan Cost Net / Rx	Plan Cost Net PMPM
ST/PA/DQM	1	1	HUMIRA PEN	INFLAMMATORY CONDITIONS	642	198	$5,918,888	$9,219	1	814	239	$7,799	8.1%
PA	2	2	REVLIMID	CANCER	327	47	$4,905,706	$15,002	2	280	43	$12,891	34.0%
ST	7	22	GILENYA	MULTIPLE SCLEROSIS	116	35	$1,861,208	$16,045	6	120	39	$16,253	5.9%
ST/PA/DQM	8	5	ENBREL SURECLICK	INFLAMMATORY CONDITIONS	241	74	$1,786,100	$7,411	7	243	81	$7,498	3.4%
PA/DQM	9	14	IBRANCE	CANCER	141	22	$1,648,483	$11,691	9	160	27	$11,139	8.8%
ST/PA	10	4	STELARA	INFLAMMATORY CONDITIONS	153	53	$1,570,386	$10,264	12	136	47	$10,184	11.8%
PA/DQM	11	7	IMBRUVICA	CANCER	115	17	$1,563,225	$13,593	19	84	13	$11,363	61.5%
ST	14	10	TECFIDERA	MULTIPLE SCLEROSIS	70	27	$1,339,367	$19,134	14	76	30	$17,164	1.2%
PA/DQM	15	43	SPRYCEL	CANCER	66	13	$1,278,535	$19,372	16	51	13	$20,205	22.3%
ST/PA	19	19	OTEZLA	INFLAMMATORY CONDITIONS	315	81	$1,083,497	$3,440	26	245	76	$3,345	30.4%
ST/PA/DQM	20	17	XTANDI	CANCER	93	22	$1,073,293	$11,541	21	86	17	$10,456	17.7%
PA/DQM	24	87	TASIGNA	CANCER	42	10	$885,682	$21,088	45	29	9	$21,941	37.2%
ST/PA	25	27	COSENTYX PEN (2 PENS)	INFLAMMATORY CONDITIONS	154	46	$832,378	$5,405	55	88	26	$5,959	56.5%
ST/PA/DQM	26	60	FORTEO	OSTEOPOROSIS	189	55	$831,049	$4,397	18	252	57	$3,874	16.1%
PA	28	30	POMALYST	CANCER	28	11	$803,632	$28,701	47	41	10	$14,751	31.0%
PA/DQM	29	24	IMATINIB MESYLATE	CANCER	81	18	$754,109	$9,310	23	72	17	$11,564	10.7%
PA	31	29	DUPIXENT	SKIN CONDITIONS	229	54	$747,584	$3,265	130	68	16	$3,402	218.6%
ST/PA	33	37	XELJANZ XR	INFLAMMATORY CONDITIONS	136	43	$693,001	$5,096	51	119	37	$4,760	20.6%
ST/PA/DQM	36	25	HUMIRA	INFLAMMATORY CONDITIONS	66	22	$683,635	$10,358	35	81	25	$9,124	8.8%
N/A	38	147	GAMUNEX-C	IMMUNE DEFICIENCY	71	14	$670,905	$9,449	80	62	11	$6,537	63.2%
ST/PA/DQM	42	57	AVONEX PEN	MULTIPLE SCLEROSIS	42	13	$653,107	$15,550	41	39	13	$17,116	3.5%
ST/PA/DQM	43	44	ENBREL	INFLAMMATORY CONDITIONS	74	27	$646,172	$8,732	36	84	31	$8,747	13.3%
PA/DQM	44	48	OFEV	IDIOPATHIC PULMONARY FIBROSIS	65	11	$641,301	$9,866	49	64	11	$9,240	6.9%
PA/DQM	47	35	TAGRISSO	CANCER	42	8	$630,602	$15,014	368	5	1	$14,820	739.1%
ST/PA	48	28	HUMIRA(CF) PEN	INFLAMMATORY CONDITIONS	78	33	$622,744	$7,984					
				Total Top 25:	3,576		$34,124,589	$9,543		3,299		$8,939	14.1%
				Differences Between Periods:	277		$4,635,022	$604					

Peer = Express Scripts Peer 'Government - Northeast Region' market segment

State Group Health Historical Pharmacy Spend

Group	Rx Component	Actual FY18	Projected FY19[1]
Commercial	Gross Claims	$133,232,488	$147,338,333
	Claims net of rebates	$103,895,047	$113,597,854
	Administrative fees[2]	$140,875	$179,043
EGWP	Gross Claims	$109,898,087	$123,380,893
	Claims net of rebates	$89,668,914	$101,789,236
	Claims net of rebates and EGWP payments[3]	$60,626,011	$67,733,699
	Administrative fees[2]	$2,437,099	$2,725,298
Total Plan Cost		$167,099,032	$184,235,894

[1] Based on actual claim experience Q1 to Q3 FY19 and projected Q4 FY19 claims.

Annual pharmacy trend of 10% for FY18-FY19 and 5% for FY19-FY20.

[2] FY19 admin fees are based on actual fees paid from July 2019 to May 2019 and projected June 2019 fees.

[3] EGWP payments include direct subsidies, coverage gap discount program, and reinsurance amounts attributable to claims period.

FY20 GHIP Forecast for Commercial and EGWP

	Commercial	EGWP	Total
Member Count[1]	101,017	26,741	127,758
Total Gross Rx Claims[2]	$151,600,000	$129,100,000	$280,700,000
- Direct Subsidy[3]	-	$2,600,000	$2,600,000
- Coverage Gap Discount[3]	-	$21,000,000	$21,000,000
- Catastrophic Reinsurance[3,4]	-	$14,300,000	$14,300,000
Rx Rebates[5]	$40,300,000	$26,300,000	$66,600,000
Total Net Rx Claims	**$111,300,000**	**$64,900,000**	**$176,200,000**
Per Member Per Year (PMPY)	**$1,102**	**$2,427**	**$1,379**

1. Total member enrollment excludes 524 Medicfill members that do not have pharmacy coverage
2. FY20 projected claims reflect incremental contract savings based on ESI final contract renewal proposal (effective 7/1/19 for Commercial and 1/1/20 for EGWP)
3. EGWP plan runs on a calendar year basis while FY20 runs 7/1/19-6/30/20; CY2019 and CY2020 EGWP revenue projected PMPM payments provided by ESI and reflected in FY20 forecast on an incurred basis
4. Catastrophic reinsurance amounts based on CY2019 actual and CY2020 projected monthly prospective payment amounts only; excludes estimated CY2018 EGWP financial reconciliation payment to be received in January 2020 (approx. $4.1m catastrophic reinsurance true-up and $1.2m low-income cost sharing subsidy); excludes potential CY2019 financial reconciliation payment to be received in January 2021
5. Based on actual rebates received over past eight quarters and improved minimum rebate guarantees from ESI final contract renewal proposal (effective 7/1/19 for Commercial and 1/1/20 for EGWP)

Limitations/Areas of Concern

- Current contract provisions do not allow SEBC to purchase select drugs/services from another source

- EGWP plan is subject to CMS oversight, requires PBM for administration and provides significant revenue payments/accounting benefits to State

- SEBC needs resources of a PBM to administer drug benefits

- Prescription benefits are important part of overall compensation/retiree package – formulary, network or administrative changes could result in member impact

Thank You

Phone: 1-800-489-8933

Email: benefits@delaware.gov

Website: de.gov/statewidebenefits

Appendix 2

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Presentation to the
Pharmaceutical Purchasing Study Group
September 20, 2019

PRICING AND PAYMENT FOR PRESCRIBED DRUGS IN MEDICAID

Medicaid drug costs are a factor of:

- Ingredient Costs
- Dispensing Fee
- Drug Rebate

INGREDIENT COSTS

- Medicaid pays pharmacies for the cost of drugs dispensed to Medicaid beneficiaries.
- The federal government requires states to use the actual acquisition cost (AAC) to set payment rates. National Average Drug Acquisition Cost (NADAC) data is used to measure AAC.
- Pharmacies negotiate prices to purchase drugs from manufacturers or wholesalers.

DISPENSING FEE

States have flexibility to establish a reasonable professional dispensing fee.

In most cases Delaware Medicaid's dispensing fee is $10 per prescription.

The dispensing fee is $27 for certain specialty drugs and clotting factor.

DRUG REBATE

Federal law requires manufacturers of drugs covered under Medicaid to participate in the federal drug rebate program.

Medicaid programs must cover almost all FDA-approved drugs produced by these manufacturers.

States may also negotiate supplemental rebates in addition to the federal statutory rebates.

SUPPLEMENTAL DRUG REBATES / SOVEREIGN STATES DRUG CONSORTIUM (SSDC)

Delaware participates in the SSDC, a multi-state purchasing pool to negotiate supplemental drug rebates.

The SSDC is an organization of 12 state Medicaid programs to collectively solicit and evaluate offers from manufacturers.

The SSDC state Medicaid programs represent over 7 million covered lives and total annual drug spending of nearly $7 billion.

SUMMARY OF PHARMACY EXPENDITURES

January–December 2018 — Delaware Medicaid and CHIP Fee for Service and Managed Care Pharmacy Expenditure

DRUG CLASS	CLAIMS	% CLAIMS	DOLLARS	% DOLLARS
Traditional	2,600,081	99%	$142,088,200	58%
Specialty	27,249	1%	$102,054,600	42%
Total	2,627,341	100%	$244,142,800	100%

TOP DRIVERS BY THERAPEUTIC CLASS

THERAPEUTIC CLASS	CLAIMS	DOLLARS	% DOLLARS OF TOTAL DOLLARS
Specialty — HIV	11,812	$73,524,798	30%
Traditional — Diabetes	87,907	$23,427,793	10%
Specialty — Rheumatoid Arthritis and Other Inflammatory Conditions	2,962	$17,617,180	7%
Traditional — Asthma	152,011	$17,437,885	7%
Traditional — Attention Disorders	102,144	$17,025,069	7%
Specialty — Hepatitis	1,811	$13,535,904	6%
Traditional — Mental/Neuro Disorders	184,182	$11,815,907	5%
Traditional — Seizures	148,616	$10,611,116	4%
Traditional — Other	272,93	$10,845,350	4%
Traditional — Substance Abuse/Dependence	52,230	$10,774,87y	4%

TOP DRIVERS BY BRAND DRUG NAME - DOLLARS

EXAMPLE BRAND NAME(S)	THERAPEUTIC CLASS	CLAIMS	DOLLARS	% DOLLARS OF TOTAL DOLLARS
Humira	Specialty — Rheumatoid Arthritis and Other Inflammatory Conditions	1,530	$8,695,543	4%
Vyvanse	Traditional — Attention Disorders	28,102	$6,083,204	3%
Harvoni	Specialty — Hepatitis	565	$7,092,466	3%
Suboxone, Buprenorphine/Naloxone	Traditional — Substance Abuse/Dependence	47,570	$7,532,137	3%
Genvoya	Specialty — HIV	2,270	$6,524,817	3%
Advate	Specialty — Hemophilia	18	$5,477,838	2%
Epclusa	Specialty — Hepatitis	198	$4,779,864	2%
Proventil, Accuneb	Traditional — Asthma	72,971	$4,855,339	2%
Lantus, Toujeo	Traditional — Diabetes	12,043	$4,569,905	2%
Lyrica	Traditional — Neurological Disorders	3,732	$4,557,854	2%

TOP DRIVERS BY BRAND DRUG NAME – CLAIMS

EXAMPLE BRAND NAME(S)	THERAPEUTIC CLASS	CLAIMS	DOLLARS	% CLAIMS OF TOTAL CLAIMS
Proventil, Accuneb	Traditional — Asthma	72,971	$4,855,339	3%
Norco	Traditional — Pain	55,250	$771,326	2%
Neurontin	Traditional — Other	54,284	$580,895	2%
Lipitor	Traditional — High Cholesterol	51,880	$374,393	2%
Prilosec	Traditional — Ulcer Disease	51,431	$205,948	2%
Zyrtec	Traditional — Allergies	50,819	$192,115	2%
Flovent, Qvar/ale	Traditional — Allergies	49,161	$2,532,187	2%
Suboxone, Buprenorphine/Naloxone	Traditional — Substance Abuse/Dependence	47,570	$7,532,137	2%
Zestril	Traditional — High Blood Pressure/Heart Disease	47,547	$127,245	2%
Amoxil	Traditional — Infections	43,939	$203,728	2%


THANK YOU

Delaware Department of Correction Appendix 3

Marc Richman, Ph.D. Bureau Chief. Department of Correction, Healthcare Services

Key Data elements:

- Over 18k prescription fills per month
- Over 7100 Over the Counter medications each month
- Approximately 3900 offenders on medication
- Total of 10 sites across the state (4 Prisons, 6 work Release/VOP)
- Controlled Substances: 1471 Rx/mos; 584 offenders
- HCV offenders: 27 offenders/mos
- HIV offenders: 70 offenders/mos
- Psychotropic Meds: 1894 client/mos

Contractor: Correct Rx

FY 2020 and FY 2021 Costs
(see attached spreadsheet)

Essential Components of DDOC Pharmacy Contract:*****

- 7 day a week delivery (delivery within 24 hours following order/process)
- Full time Pharmacists on-site at EACH Level 5 prison and coverage for each Level 4 Work Release/Violation of Probation Center providing critical functions such as:
    - Cutting edge clinical programs (e.g., diabetes education)
    - Consult on disease states and pharmaeconomics
    - With medical provider, manage high acuity patients
    - Help manage patient polypharmacy
    - Facilitating the Pharmacy and Therapeutics (P and T) Quarterly Meeting
    - Cost Savings methods and strategies
    - Utilization Review

	Pharmaceuticals	Management Fee/Pharmacist	Total
FY11	$4,003,426.25	$696,480.00	$4,699,906.25
FY12	$5,124,626.11	$976,094.76	$6,100,720.87
FY13	$4,760,027.47	$1,226,311.23	$5,986,338.70
FY14	$5,440,210.67	$1,308,660.00	$6,748,870.67
FY15	$7,302,669.78	$1,466,698.83	$8,769,368.61
FY16	$9,171,966.82	$1,623,328.80	$10,795,295.62
FY17	$12,558,885.95	$1,647,333.03	$14,206,218.98
FY18	$12,229,499.28	$1,536,022.46	$13,765,521.74
FY19	$12,516,939.44	$1,637,557.00	$14,154,496.44
FY20 (estimated)	$13,110,500.00	$1,735,200.00	$14,845,700.00
FY21 (estimated)	$14,028,200.00	$1,787,200.00	$15,815,400.00

NOTE: Anticipate percentage of offenders receiving MAT (Medication Assisted Treatment) to increase in FY20. Will monitor monthly charges and adjust anticipated cost as needed for methadone, suboxone and vivitrol.

Appendix 4

MEMORANDUM

TO: Rep. Ray Seigfried
FROM: Debbie Gottschalk, Legislative Attorney
DATE: September 12, 2019
RE: HCR 35 Study Group & Determining Private Interests

Question Presented

What questions can members and participants be asked to identify personal or private interests during discussions of the HCR 35 Interagency Pharmaceuticals Purchasing Study Group ("HCR 35 Study Group")?

Law

Our system of government is based on citizen participation. Participation by citizens with subject matter expertise from their professional or personal life experience informs policy decisions.

Delaware law balances the need for stakeholder participation with the need to prevent self-enrichment by prohibiting members of a task force[1] from participating in a matter on behalf of the State when the member has a personal or private interest which may impair the person's independent judgment.[2] There is no restriction on the ability of a person with a personal or private interest responding to questions regarding the matter.[3] Delaware law does not address the appearance of a conflict of interest.

State law defines when a person has a financial interest and when that interest tends to impair a person's independence of judgment.

A person has a "financial interest" in a private enterprise if:

a. The person has a legal or equitable ownership interest in the enterprise of more than 10% (1% or more in the case of a corporation whose stock is regularly traded on an established securities market);

b. The person is associated with the enterprise and received from the enterprise during the last calendar year or might reasonably be expected to receive from the enterprise during the current or the next calendar year income in excess of $5,000 for services as an employee, officer, director, trustee or independent contractor; or

c. The person is a creditor of a private enterprise in an amount equal to 10% or more of the debt of that enterprise (1% or more in the case of a corporation whose securities are regularly traded on an established securities market).[4]

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[1] 29 *Del.C.* § 5804(11).
[2] 29 *Del.C.* § 5805(a)(1).
[3] 29 *Del.C.* § 5805(a)(1).
[4] 29 *Del.C.* § 5804(5).

A person has "an interest which tends to impair the person's independence of judgment in the performance of the person's duties with respect to any matter" when:

a. Any action or inaction with respect to the matter would result in a financial benefit or detriment to accrue to the person or a close relative to a greater extent than such benefit or detriment would accrue to others who are members of the same class or group of persons; or

b. The person or a close relative has a financial interest in a private enterprise which enterprise or interest would be affected by any action or inaction on a matter to a lesser or greater extent than like enterprises or other interests in the same enterprise.[5]

Ascertaining the Existence of a Private Interest

While there is no restriction on the ability of a person with a personal or private interest to answer questions concerning a matter being reviewed by the State, determining whether a person has a personal or private interest can support the integrity of the final work product. Answers to the following questions should determine if, under Delaware law, a person has a financial interest and if that interest tends to impair independence of judgment.

1. Do you or a close relative[6] have a legal or equitable ownership interest of more than 10% (or 1% or more in the case of a corporation whose stock is regularly traded on an established securities market) in a pharmacy, pharmacy benefit manager, pharmaceutical distributor, or pharmaceutical manufacturer?

2. Are you or a close relative associated with a pharmacy, pharmacy benefit manager, pharmaceutical distributor, or pharmaceutical manufacturer?

   If yes –
   Did you receive income in excess of $5,000 for services as an employee, officer, director, trustee, or independent contractor last year?

   Do you expect to receive this year or next year income in excess of $5,000 for services as an employee, officer, director, trustee, or independent contractor.

3. Are you or a close relative a creditor of a pharmacy, pharmacy benefit manager, pharmaceutical distributor, or pharmaceutical manufacturer in an amount equal to 10% or more of the debt of that enterprise (1% or more in the case of a corporation whose securities are regularly traded on an established securities market)?

4. Would an action or inaction with respect to State contracts regarding the purchase of pharmaceuticals, including insurance reimbursement rates, result in a financial benefit or detriment to you or a close relative to a greater extent than such benefit or detriment would accrue to others who are members of the same class or group of persons?

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[5] 29 *Del.C.* § 5805(a)(2).

[6] "'Close relative' means a persons' parents, spouse, children (natural or adopted) and siblings." 29 Del.C. § 5804(1).

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Appendix 5

Prescription Drug Resource Center

2019 Mapping and Tracking State Approaches in Prescription Drug Laws

May 20, 2019

Compiled by the NCSL Health Program, Colleen Becker, Policy Specialist

During the past few years, states have addressed the high cost of prescription drugs with innovative or unconventional policies. This report provides a snapshot of several state actions taken during the 2019 legislative session. You can find extensive reports and information on these topics and others at NCSL's Prescription Drug Policy Resource Center. Through the center, you can also access NCSL's Prescription Drug Law Database, where you can find direct links to the text of more than 5,475 pieces of proposed and enacted legislation.

Importation

Although not a new idea, the importation of prescription drugs from sources outside the U.S. has been rapidly gaining the attention of state lawmakers. The Food and Drug Administration (FDA) has always held that importing drugs into the United States for personal or commercial use is against federal law. This is because pharmaceutical products from foreign pharmacies are not subject to the FDA's rigorous inspection, efficacy and safety standards. However, the ban has not been enforced in many cases. According to a Kaiser Family Foundation poll conducted in 2016, 8% of respondents, or about 19 million adults, said they or someone in their household had, at some point, used the Internet or crossed a border to buy prescription drugs at prices that are sometimes 40% to 60% less than U.S. retail.

Although the FDA considers the importation of pharmaceuticals illegal, some state legislators have chosen to test the waters and see if there is room for compromise. In 2018, Vermont became the first state to pass legislation to develop an importation program. An initial report to the legislature suggested that the program would mean approximately $1 million to $5 million annual savings for the state's private health plan enrollees.

Vermont's measure specifies that the program must ensure cost savings and comply with federal safety and efficacy standards. President Trump recently announced that he backs state importation programs. However, Health and Human Services Secretary Alex Azar, who must approve these proposals, has openly criticized them.

Plans in two other states—Colorado (SB 05) and Florida (HB 19)—have also been endorsed by Trump. For 2019, at the time of this report, at least 28 bills have been introduced in 16 states.

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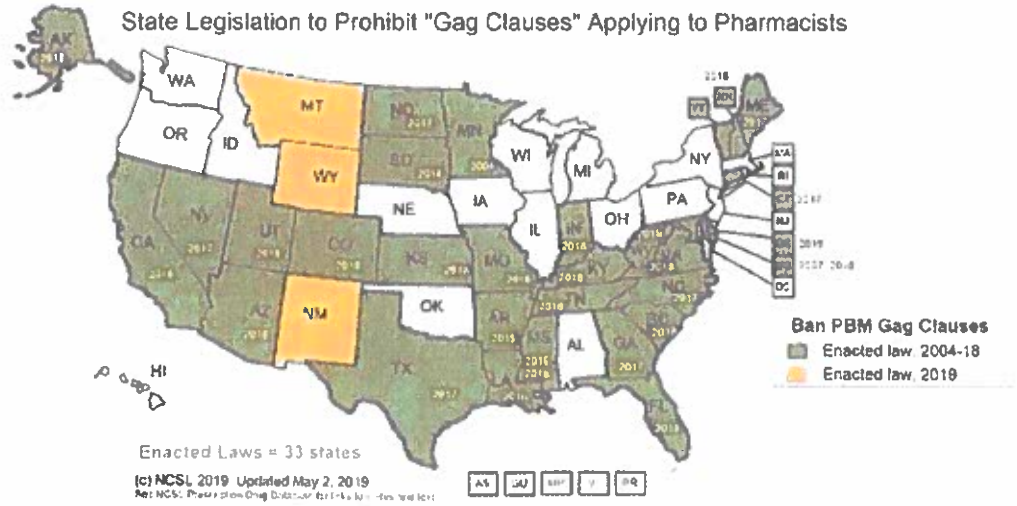
Gag Clauses

One theme recurring from 2018 is the elimination of contractual gag clauses between PBMs and pharmacists. Gag clauses prohibit a pharmacist from disclosing a cheaper alternative to patients, sometimes enforced by a fee. To date, 33 states have enacted legislation related to gag clauses. Similarly, copay clawbacks—when a patient's copay is more than the total cost of the drug to the PBM or insurer and those entities essentially "claw back" the overpayment from the pharmacy—are also often prohibited in these measures.



Fiduciary Duty

Some states are considering requiring PBMs to act as a fiduciary. A fiduciary is a person or entity who holds a legal or ethical responsibility to act in the best interest of their clients. At the time of this report, one state—Nevada—had implemented a law requiring that a PBM has a fiduciary duty and at least four states have considered such laws. Nevada's law specifies that a PBM has a fiduciary duty to a third party with which it has entered into a contract to manage that party's pharmacy benefits plan. This means the PBM must act in the best interest of the pharmacies or consumers it serves, rather than the best interests of a health plan.

Registration and Licensing

Other state actions would require PBMs to either be licensed or registered with a state administrative agency before conducting business in the state. Often, the agency that oversees PBMs is the office of the insurance commissioner, which can investigate claims of wrongdoing. Typically, these laws require a PBM to apply for and annually renew their registration, pay fees, and maintain a board—as well as identify their members. At least 20 states have enacted this type of legislation in recent years.

Manufacturer Price Transparency

A recurring theme is transparency in how prescription drugs are priced. Fifty bills in 21 states were introduced on this topic in 2019 and, as in the case of PBMs, the actions states took were diverse.

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Several states pursued legislation to commission a workgroup or a study to investigate increasing drug prices but so far only one bill has passed. Indiana (HB 1029) enacted legislation to form a prescription drug pricing study committee tasked with investigating issues consumers face related to prescription drug pricing, access and costs.

Another common approach is to require disclosure of certain information to the state. Shedding light on the entire supply chain, sweeping legislation was enacted in Washington (HB 1224) requiring insurance carriers, PBMs and manufacturers to report various data to the health care authority.

The bill is comprehensive, but highlights include:

- Insurers must report the 25 prescription drugs most frequently prescribed by health care providers participating in the plan's network, as well as the 25 costliest prescription drugs.
- PBMs must report the total dollar amount of all discounts and rebates received from the manufacturer, as well as how much of those rebates are retained by the PBM for each drug on the PBM's formularies. PBMs must also disclose how much they pay retail pharmacies and the negotiated price that health plans pay the PBM for each drug on the PBM's formularies.
- A manufacturer must submit to the state a description of all factors used to make the decision to either set or increase the list price of the drug. In the event of a price increase—defined as a list price increase of 20% or more annually, or a 50% increase over three years—a covered manufacturer must submit the amount of the increase and provide a reason why. This includes any drug a manufacturer intends to introduce at a list price of $10,000 or more for a course of treatment lasting less than one month or a 30-day supply. It would also include drugs already on the market costing more than $100 for a course of treatment lasting less than one month or a 30-day supply.

Step-Therapy and Prior Authorization

Policies affecting step-therapy, also known as "fail first," and prior authorization protocols were also on the minds of state lawmakers in 2019. These utilization management tools are often used by insurers and PBMs to encourage providers and patients to choose less costly treatments while still maintaining an optimal quality of life. PBMs and carriers sometimes make patients start on a cheaper alternative drug and "step" through to the next, more expensive, tier if necessary. A health care provider must obtain prior authorization from the plan or PBM to start a patient on a higher tier.

As of May 2019, at least 16 bills in 11 states were enacted related to these mechanisms. Several measures would require insurance carriers to develop a clear request process when step-therapy is used. In their 2019 sessions, Oklahoma (SB 509) and Washington (HB 1879) enacted this type of legislation. An example of language is excerpted below from the Washington law:

"When coverage of a prescription drug for the treatment of any medical condition is subject to prescription drug utilization management, the patient and prescribing practitioner must have access to a clear, readily accessible, and convenient process to request an exception through which the prescription drug utilization management can be overridden in favor of coverage of a prescription drug prescribed by a treating health care provider."

At least two states—Arkansas (SB 446) and North Dakota (HB 1469)—adopted laws prohibiting step-therapy protocols specifically for cancer patients.

Several measures also modified the prior authorization and appeals process. In Kentucky (SB 54), health insurance carriers will be required to develop and adopt a process for electronically requesting and transmitting prior authorization for a prescription drug by health care providers. Under the new law, insurers will be required to render a decision for urgent health care services, and to notify the covered person or provider of that decision, no later than 24 hours after the completed request is received. If the member is requesting nonurgent health care services, the carrier must render a decision and notify the covered person or provider within five days of receipt.

Conclusion

Though some states have concluded their legislative sessions, the conversation on how to make prescription drugs more affordable continues. While there is bipartisan agreement in Congress that action must be taken, progress is slow. In response, state lawmakers have taken up the mantle to try to alleviate the high cost of drugs for both their constituents and their state budgets. Even though policymakers may disagree in many other topic areas, state legislators have come together to develop real world solutions to the drug cost conundrum. As the clock winds down in statehouses across America, time will tell as to what new laws will prevail and how effective they will be.